Bright Star Orthodontics

Consent for use and disclosure of health information
HIPAA - Health Insurance Portability and Accountability Act

Date:_________________

Patient Name:_______________________________

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnosis, treatment and any plans for future care or treatment. We utilize this information to:

- Plan your care and treatment
- Communicate with other health professionals who contribute to your care
- Submit your diagnosis and treatment information to insurance companies or others

By signing this document, and "only as permitted by State or Federal Law", you are giving this practice your consent to do the following:

- To disclose, as many be necessary, your health/dental information to other healthcare providers (such as, referrals to or consultation with other healthcare professionals, laboratories, hospitals, etc.) for your treatment and/or healthcare.
- To request from other health/dental care entities (i.e., doctors, dentists, hospitals, labs, imaging centers, etc.) specific information we may need for planning your care and treatment.
- To submit your diagnosis and treatment information to insurance company(s), other agencies and/or individual(s) for payment of services.
- Leave appointment reminders or information we believe necessary for treatment or payment with a family member or on an answering machine. The information will be the minimum necessary in our professional judgment.
- Discuss your health information (only as necessary in our judgment) with family members or other persons who are or may be involved with your healthcare treatment or payments.
- Please list by name and relationship any person with whom we may not share your health or payment information (based on professional judgment, this practice has the right to not honor your request).

We will make available to you, at your request, our "Notice of Privacy Practice" that provides a more complete description of health information uses and disclosures, which is outlined about, as required by the HIPAA standard. You may request a copy of our Notice of Privacy Practices by contacting our office at (856) 728-7775 or via email at bracedoc1234@yahoo.com.

I have read the consent form and I understand by signing this form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activity, and health care operations.

____________________________________ ____________________________________

Printed name of person signing Signature

*If someone other than the patient is signing, are you the parent, legal guardian, and legal custodian or have Power of Attorney for treatment and/or payment for this patient. Yes [ ] No [ ]

RELATIONSHIP TO PATIENT___________________________________

If you are not the parent, please provide a copy of your legal authority for this patient.